Complete Summary

GUIDELINE TITLE

Domestic violence.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Sep. 46 p. [87 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 51 p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Domestic violence

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

- To increase training opportunities for staff for screening and assessment of domestic violence
- To improve the knowledge of health care professionals of community resources (shelters, domestic violence advocacy services) for domestic violence
- To facilitate the establishment of the health care setting as a safe, comfortable and appropriate place in which to discuss issues of domestic violence
- To improve the identification of victims of domestic violence and offer resources

TARGET POPULATION

Individuals at risk for, or presenting with, signs of domestic violence, including adolescents through seniors from all ethnic groups, and heterosexuals and same-sex relationships

Child abuse and vulnerable adult abuse are outside the boundaries of this guideline.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screening measures for domestic violence
2. Standard care of injuries and/or symptoms of domestic violence
3. Staff and patient education on domestic violence
4. Documentation procedures for health care providers dealing with domestic violence
5. Referral and use of resource information

MAJOR OUTCOMES CONSIDERED

- Rate of mental disorders, depression in physically abused women
- Rate of physical abuse during pregnancy
- Effectiveness of various screening methods for domestic abuse

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline draft, discussion and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member medical groups during an eight-week review period of "Critical Review."

Each of the Institute's participating member groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating medical groups following general implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group

Following the completion of the "Critical Review" period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary, and a written response is prepared to address each of the suggestions received from medical groups. Two members of the Committee on Evidence-Based Practice carefully review the Critical Review input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of two questions: (1) Have the concerns of the

medical groups been adequately addressed? (2) Are the medical groups willing and able to implement the guideline? The committee then either approves the guideline for pilot testing as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Medical groups introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer, and other practice systems. Evaluation and assessment occur throughout the pilot test phase, which usually lasts for three months. Comments and suggestions are solicited in the same manner as used during the "Critical Review" phase.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, and the Committee on Evidence-Based Practice reviews the revised guideline and approves it for implementation.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC) and the Institute for Clinical Systems Improvement (ICSI): In addition to updating their clinical guidance, ICSI has developed a new format for all guidelines. Key additions and changes include: combination of the annotation and discussion section; the addition of "Key Points" at the beginning of most annotations; the inclusion of references supporting the recommendations; and a complete list of references in the Supporting Evidence section of the guideline. For a description of what has changed since the previous version of this guidance, refer to Summary of Changes – September 2006.

The recommendations for the management of domestic violence are presented in the form of an algorithm with 10 components, accompanied by detailed annotations. An algorithm is provided for Domestic Violence; clinical highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) definitions are provided at the end of the "Major Recommendations" field.

Clinical Highlights

- Domestic violence should be a consideration in all patient encounters and should be conducted in private, with only the provider and the patient present. In certain situations a trusted interpreter or language line service (not a friend or a family member) may be necessary. Simply raising the question and affirming the difficulty of an abusive situation is, in and of itself, an important intervention. You cannot and do not have to fix the problem. (*Annotations #1, 4, 8*)
- Raise clinic and patient awareness regarding signs and symptoms of domestic violence. Possible strategies include:
    - Staff training (clinical, office, emergency room [ER], urgent care)

- Signage in the clinic, ER or urgent care
- Brochures/literature in the reception area and examining rooms

(*Annotation #1*)

- Staff should have a heightened awareness of a possible domestic violence situation when the patient presents with:
  - Somatic complaints without diagnosis (chronic pain, fatigue, headache)
  - Post-traumatic stress symptoms
  - Gastrointestinal pain
  - Unexplainable neurologic changes
  - Depression
  - Multiple or erratic visits with a series of vague complaints

(*Annotation #2*)

- Domestic violence can be seen in all age groups, adolescents through seniors. (*Annotation #4*)
- When patients confirm that they are or have been in a domestic violent situation, current needs should be assessed as well as a follow-up plan requested with them. (*Annotations #8, 9, 10*)
- Interventions in the primary care setting can improve outcomes in identified individuals. (*Annotation #9*)
- Regular follow-up can help patients identify the potential impact of domestic violence on their other health conditions. (*Annotation #4*)

Domestic Violence Algorithm Annotations

1. **Implement Education Program on Domestic Violence**

   Key Points:

   - Health care staff, (clinical, office, ER, urgent care) must receive adequate training in order to effectively identify and respond to domestic violence.
   - Materials should be available in all exam rooms and staff and patient restrooms.
   - The goals of domestic violence education in the clinical setting are to increase awareness about this problem, as well as to provide information about the internal and external resources available for support.

   Staff Training

   Many health care professionals lack training in and knowledge about domestic violence. In addition, many health care providers hold attitudes and misconceptions that serve as barriers to addressing domestic violence in their parent's lives.

Health care staff (clinical, office, ER, urgent care) must receive adequate training in order to effectively identify and respond to domestic violence. Adequate training includes an opportunity to address barriers to identification and intervention, as well as to learn the necessary clinical skills. Early in the effort it is essential that training occur within the clinic that ties in with established local community-based advocate programs. Follow-up training over time is also helpful to health care staff in this new and often challenging clinical area. Providing training and education to recognize the problems of domestic violence and work effectively with its victims requires long-term organizational commitment.

Refer to the original guideline document for available items to assist with staff training (i.e., staff training outline, safety plans for patients, documentation protocols, protocols for dealing with threatening or abusive persons in the clinic setting).

It is not unusual for the same clinic and/or provider to see multiple members of the same family. When domestic violence is involved, this can present with special challenges for safety and confidentiality considerations. Consider having members see different providers.

Patient

Materials should be available in all exam rooms and staff and patient restrooms. In addition, posters could be displayed in waiting areas with culturally diverse messages indicating that the health care setting is a safe place in which to talk about domestic violence.

Clinical Setting

The goals of domestic violence education in the clinical setting are to increase awareness about this problem as well as to provide information about the internal and external resources available for support. Possible educational strategies include:

- Displaying posters regarding domestic/family violence prevention, including resource contact information, cycle of abuse, cultural influences, etc
- Publishing articles regarding domestic violence and available internal and external resources in employee publications
- Posting violence prevention information in restrooms that would indicate that health care staff members are a safe resource
- Staff training that includes use of community-based domestic violence programs as a resource
- Establish strong ties and assure ongoing collaboration with local community- based domestic violence shelters and advocacy programs

Evidence supporting this recommendation is of classes: C, D, R

2. **Patient Presenting with Risk Factors/Warning Signs of Domestic Violence?**

Key Points:

- Either male or female may be a victim, perpetrator or both of domestic violence in either a heterosexual or same-sex relationship.

Both genders are screened if risk factors or warning signs of domestic violence are present. Either male or female may be a victim, perpetrator or both of domestic violence in either a heterosexual or same-sex relationship. (Refer to Annotation Appendix A, "Myths About Domestic Violence" in the original guideline document.) Therefore, providers should not assume that the perpetrator is of the opposite sex.

The following is a list of common presenting symptoms that may represent the effects of domestic violence:

Any Injury. Particularly suspicious injuries include:

- Burns or bruises in unusual locations
- Central injuries (e.g., chest, breasts, abdomen, pelvis, perineum)
- Delay in seeking treatment
- Facial injuries (e.g., teeth, jaw, ruptured eardrum)
- Human bites
- Injuries at various stages of healing
- Injuries from weapons (old scars or new signs)
- Pattern of injury not consistent with history
- Previous assault
- Repeated visits for minor trauma

Somatic Complaints Without Diagnosis, including:

- Chronic pain (e.g., abdominal, pelvic, back or neck pain)
- Fatigue
- Insomnia/nightmares
- Unexplainable neurologic changes
- Vague complaints
- Headaches

Sexual Problems, Gynecologic/Gastrointestinal Conditions, including:

- Coercion in sexual relationships
- Irritable bowel syndrome
- Pelvic inflammatory disease (PID)
- Sexual dysfunction
- Sexually transmitted diseases (STDs)
- Unexplained chronic gynecologic problems (e.g., vaginitis, pelvic pain)

Psychological Problems, including:

- Alcohol/drug use
- Anxiety/panic attacks
- Post-traumatic stress symptoms (e.g., hyperanxiety, flashbacks)

- Depression
- Difficult patient
- Eating disorders
- Excessive use of or requests for tranquilizers, sedatives, or narcotics
- Low self-esteem
- Suicidal ideation or attempt

Pregnancy/Pregnancy Related Problems, including:

- Abnormal bleeding
- Alcohol/drug use, cigarette smoking
- Extreme worry about health of unborn child
- Inadequate maternal nutrition
- Late or inadequate prenatal care
- Past pregnancy complications (e.g., spontaneous abortion, first or second trimester bleeding, poor weight gain, preterm labor, preterm birth, low birth weight infant, abruptio placentae)
- Preterm labor
- Teen pregnancy

Behavioral Presentations, including:

- Angry or anxious body language
- Comments about emotional abuse or a friend who is abused
- Crying or sighing
- Defensiveness
- Minimizing statements
- Searching/engaging (fearful or poor) eye contact
- Very flat affect--little or no emotional expression

Change in Office Visit Patterns, including:

- Appointments canceled by partner
- Change to use of emergency room or urgent/after hours care rather than office visits
- Frequent changes of health care provider
- Frequent late arrival
- Missed or late appointments
- Sudden increase or decrease in frequency of visits

Angry, Controlling, Coercive Behavior of Partner/Companion

- Fear of partner, defers to partner to answer questions
- Partner attempts to minimize time patient is alone with provider
- Partner does not allow patient to obtain or take medication
- Partner hovers, appears overly concerned, won't leave patient unattended
- Reluctance to speak in front of or to disagree with partner

Lifestyle Changes

- Isolating self from family and/or friends (turning down/refusing opportunities to spend time with)
- Partner has to be consulted with and/or attend social events
- Abusive partner seems to be at a lot of social functions without the abused partner and excuses for absence may seem unusual

Evidence supporting this recommendation is of classes: A, B, C, D, R

4. **Screening for Domestic Violence/Standard Care of Injuries or Symptoms**

Key Points:

- Battered women remain underdiagnosed by the medical community generally, and by primary care physicians specifically.
- Each provider should draw on his or her own language skills and experience to find the approach that feels most comfortable in the patient encounter.
- The goal for providers is to become comfortable with asking about domestic violence and making it part of the clinical routine.

Screening for Domestic Violence

The screening and assessment interview should be conducted in **private, with only the provider and the patient present**, including screening teens about their dating relationships. It can occur during the initial screen while asking about smoking and taking vital signs. Or it may be done during the social history portion of the encounter. If evaluating the patient for an injury, either the triage nurse or the examining provider could ask the listed questions. The goal for providers is to **become comfortable with asking about domestic violence and make it part of the clinical routine**, much like gathering information on smoking and alcohol consumption. When screening patients, the cultural, ethnic and religious background of the patient needs to be acknowledged, including insuring the confidentiality of the interpreters. Patient behaviors such as smiling, minimizing danger, stoicism, and lack of trust in health care staff can easily be misinterpreted.

For more information on routine screening for domestic violence, see the NGC summaries of the ICSI Preventive Services in Adults and Preventive Services for Children and Adolescents guidelines.

Introduction or Framing Question

Introducing a domestic violence screening question seems to make both the physician and patient more comfortable. It also helps patients understand that the physician does routine screening and that they are not being singled out for any reason. Here are some examples:

> Unfortunately, violence often plays a role in our families and our communities, so I am asking all of my patients the following question:

At _____ (fill in name of hospital/clinic), we recognize that violence and abuse is common in our patients' lives, so I've begun asking about this routinely.

Screening Questions

The following is a list of questions to be used in screening for domestic violence. Depending upon the clinician's professional style and the nature of the patient's situation, some questions may be more appropriate than others.

During a clinic visit for suspicious symptoms or for any reason, the clinician may want to use a variety of questions, either indirect or direct:

Indirect

- In general, how would you describe your relationship?
- How do you and your partner settle arguments?
- Do you feel safe in your current relationship?

Direct

- Have you been hit, kicked, punched, or otherwise hurt in the past year? If so, by whom?
- Have you or your partner ever used physical force during arguments?
- Do you feel frightened by what your partner says or does?

Refer to Appendix B, "Screening Instruments" in the original guideline document for specific screening tools.

When seeing a patient again who has given an equivocal or affirmative response to previous questions about abuse:

- "We spoke about the anger and abuse at home last time. How are you doing?"

Standard Care of Injuries or Symptoms

- Treat medical injuries as indicated
- Use caution in administering or prescribing sedatives, tranquilizers, or antidepressants
- When the patient shows symptoms of underlying psychological conditions:
    - If the patient is acutely suicidal or homicidal, take the appropriate protective action.
    - Evaluate symptoms further. Consider a consultation with or referral to mental health/chemical health. Inform the patient that depression, anxiety and chemical abuse are common responses to long-term stress. If assessment of psychiatric symptoms is not appropriate at this visit, evaluate further at return visit.

        - Some patients may be unwilling to consider domestic violence resources or a domestic violence shelter for low-income victims. Consider a referral to a mental health professional who has an interest in domestic violence even if the patient doesn't have underlying psychological conditions if the provider thinks the patient might be more receptive.
    - Assess for domestic violence before prescribing anxiolytics for patients who suffer from symptoms like recurring headaches, chest pain, pelvic pain, numbness and tingling, or panic attacks.
        - Patients may be unwilling to follow-up on referrals and need further education regarding the link between domestic violence and their health issues (e.g., other chronic illnesses). Arrange for follow-up visits.

Evidence supporting this recommendation is of classes: B, C, D, M, R

5. **Domestic Violence Suspected?**

   If there is something about the patient's injuries, behaviors or reactions that indicates there is or has been abuse, recognize this as a sensitive part of the encounter. Most victims will find it difficult to discuss an abusive situation. The following are some ways to proceed in a nonthreatening, respectful manner:

   - Remain nonjudgmental and supportive
   - Be alert to any cultural influences which may be present.
   - Be clear with the patient about what characteristics of the injury lead you to believe that he or she may have been assaulted. For example: "The shape of the bruise on your face fits the shape of a fist and makes me wonder if you have been hit." If the patient denies abuse, do not insist. Accept the response.
   - Patient education materials and posters should be pointed out.
   - Inform the patient that domestic violence isn't necessarily only physical, but may also be emotional or sexual in nature.
   - Sometimes patients are reluctant to accept literature. You may want to offer information indirectly (e.g., "Perhaps someone you know can use this.").
   - Be certain to inform patients that this information is confidential, and that the clinic setting is a safe place to discuss such problems.
   - Mention that under state law, no one has the right to abuse anyone, and no one ever deserves to be abused--physical abuse is illegal.
   - It takes time and trust for patients to disclose abuse. Continue to ask and be supportive.

6. **Provider Offers Education and Resources**

   Key Points:

- All patients need to hear a clear message from the health care professional that their present concerns are understandable and that they do not deserve to be hurt.
- Resource materials should not be mailed to the patient's home. Such a mailing might result in greater danger to the patient.

When the patient denies the presence of domestic violence and there is no reason to suspect domestic violence, the health care provider only needs to have resource information available and to **convey the message that the health care setting is a safe place to ask for help if violence ever becomes a problem**.

At this point the patient may not be ready to openly discuss domestic violence, but may be willing to take written material if that material is available and if it is safe to have in his or her possession. This material might be used by the patient months after the medical encounter.

The patient should also be tactfully reassessed at the next follow-up encounter if domestic violence is suspected. A safety assessment and follow-up discussions can increase the adoption of safety behaviors, possibly preventing future abuse, and reducing danger for both victims and children.

In domestic violence, both or either the male or female may be a victim, perpetrator, or both. In addition to providing education and resources to the victim, providers may want to have resource materials available for the abuser and children who may witness domestic violence.

Evidence supporting this recommendation is of class: B, D

7. **Patient Confirms Domestic Violence?**

At this point, the patient will either confirm or deny that domestic violence is an issue in their lives. A patient may confirm domestic violence as part of a previous experience (e.g., a former relationship, parents). Even if a patient determines that the former situation is no longer a threat, the provider should still validate the patient's feeling that no one had the right to abuse him or her. The following should be done immediately when domestic violence is confirmed by the patient:

- Validate the patient's feelings (e.g., fear, shame)
- Support the patient's right not to be hurt
- Acknowledge the potential for further harm

If the patient confirms domestic violence, the provider must offer empathetic understanding of the patient's story and provide gentle, yet firm, assertions as to the reality of what he or she is suffering. The provider should clearly state that:

- The battered patient is a victim of a common, serious crime
- The batterer is always responsible for abusive acts, which are against the law

- The victim has options for how to respond to abuse – the victim can contact police, go to a shelter, contact an advocate, begin supportive care, or do nothing
- It is the batterer who is wrong; and
- The victim deserves the help he or she needs and/or wants

The healing process is assisted by education about domestic abuse.

Educational materials should be shared with the patient regarding the cycle of violence and the dynamics of power and control (refer to Appendix D, "Review of Violence Cycle Models" and Appendix E, "Safety Planning" in the original guideline document for a safety planning form).

Evidence supporting this recommendation is of class: R

8. **Discuss Immediate Safety Status**

Key Points:

- It is imperative that the health care provider inquire about the domestic violence victim's safety before the patient leaves the medical setting.
- Concerning violence toward the patient's family or vulnerable adults living within the family, the provider is mandated to report abuse and neglect within the parameters of Minnesota state law.

Discussing the patient's immediate safety will enable an abused individual to decide how best to proceed. Consider asking the following questions:

- Is the patient in immediate danger? (What does the patient anticipate will happen when/if he or she returns home?)
- Does the abuser have or use a weapon? Has the abuser threatened to kill the patient?
- Is the abuser violent toward other family members, or pets?
- Does the abuser use drugs or alcohol?
- Does the patient use drugs or alcohol to cope?
- Has the patient ever attempted or thought of attempting suicide?

It is imperative that the health care provider inquire about the domestic violence victim's safety before the patient leaves the medical setting. Assessment of safety status is not intended to produce a determination of the *actual* danger the patient is facing. Domestic violence situations are complex and batterers are unpredictable, making it impossible for anyone, even highly trained domestic violence advocates, to accurately predict what will happen next. However, reviewing the safety factors listed in this guideline provides important information to guide the provider in offering assistance to the patient.

If the batterer uses drugs or alcohol, help the patient understand the unpredictability of behavior while someone is "under the influence" of chemicals. However, alcohol and drugs do not cause abuse.

If the patient uses drugs or alcohol to cope, give the patient information about the ways in which chemical use interferes with the ability to make rational decisions and to protect oneself. Offer the patient chemical health assistance if appropriate.

Evidence supporting this recommendation is of classes: A, D, R

9. **Review Resources/Offer Support/Offer Advocate**

Key Points:

- All care settings should keep a copy of a generic safety plan available for patients to use at the time or take with them, depending on whether it is safe to do so.
- Medical settings must develop links with domestic violence resources within their regions.

Interventions in the primary care settings can improve outcomes in identified individuals.

The Danger Assessment is a tool to help assess safety status. See Appendix C, "Danger Assessment" and Appendix E, "Safety Planning" in the original guideline document for a copy of a safety planning form.

If the patient appears to be in IMMINENT DANGER of being harmed, consider the following:

- Provide imminent safety from the abuser while the patient is in the medical setting and during any transfers to other settings.
- Encourage abused women and men to consider finding a safe place to stay--with family, friends, a battered women's shelter.
- If the patient chooses not to return home, a health care staff person or advocate needs to offer assistance in obtaining safe lodging.
- Review resources and offer written materials
    - Provide the patient with a copy of a safety plan and an opportunity to discuss the plan if appropriate.
    - Offer the patient resource material on domestic violence. If the patient feels it is unsafe to take the material, at least make sure he or she has the phone number of a local shelter or hotline, and that he or she keeps the number in a safe place.
    - Do NOT suggest couples counseling. Clinical evidence suggests the perpetrator may retaliate when the couple is alone.
- Offer a domestic violence advocate. A domestic violence advocate will help ensure that the battered person and his or her children are safe and that their rights are protected.
    - Offer to help put the patient in touch with a domestic violence advocate. Advocates are trained to help the patient plan for safety and can provide for immediate shelter, transitional services, and legal advocacy.
    - Provide the patient with a private and safe place (away from abuser) to talk with an advocate by phone or in person. Offer to assist the patient with this call if appropriate.

        - Site-based advocacy services can provide face-to-face support on a 24-hour basis. Settings without on-site services can rely on local shelters or hotlines for immediate telephone contact with the patient.
    - Refer to the original guideline document for information about available crisis lines.
    - At this point the patient may not be ready to openly discuss domestic violence, but may be willing to take resource materials. Discuss safe places to keep this information; it may be used months after the health care encounter. The patient should also be tactfully reassessed at the next encounter.

Evidence supporting this recommendation is of classes: A, B, R

10. **Plan For Future Follow-Up/Documentation**

Key Points:

- It is very important that follow-up not be a time in which a provider pressures the patient about what has been done to resolve the situation.
- The primary responsibility for health care providers dealing with domestic violence includes identifying and acknowledging the abuse, providing sensitive support, clearly documenting the abuse, and providing referral and resource information.
- Proper documentation is critical in the event that the victim chooses to take legal action at the time of the visit or sometime in the future.

Plan for Future Follow-Up

- Ask the patient to schedule a return visit for follow-up in order to provide ongoing treatment of injuries, further assessment, and/or to allow the patient to get support.
- During future visits, **continued assessment and support are extremely important and should be provided in a way which is driven by the patient's readiness, not the provider's timetable for change**. Simple questions like "How are things going at home?" convey that the health care setting continues to be a safe place in which to discuss domestic violence.

Documentation

The primary responsibility for health care providers dealing with domestic violence includes identifying and acknowledging the abuse, providing sensitive support, clearly documenting the abuse, and providing referral and resource information.

Proper documentation is critical in the event that the victim chooses to take legal action at the time of the visit or sometime in the future.

Use the subjective, objective, assessment, and plan (SOAP) format to provide the standard information, as you would for any other patient encounter. Refer to the original guideline document for examples of suggested documentation using the SOAP format.

Coding

Refer to the original guideline document for information on coding.

Confidentiality

Confidentiality is a critical issue in all work with patients. The area of domestic violence poses an additional challenge in regards to patient safety. Domestic violence screening should be done with only the patient and health care provider present. If an interpreter is necessary, do not use friends or family but use a professional interpreter service or language line services.

Evidence supporting this recommendation is of classes: D, R

Definitions:

Classes of Research Reports:

A. Primary Reports of New Data Collection:

Class A:

- Randomized, controlled trial

Class B:

- Cohort study

Class C:

- Non-randomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D:

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis

- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for Domestic Violence.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Guideline recommendations may improve the care of domestic violence victims by providing clinicians with a guide for identifying and effectively intervening in domestic violence-related health care problems.
- Safety assessment and discussion of the cycle of violence and safety behaviors can make a positive difference. In a study of 132 abused pregnant mothers, including white, Hispanic, and African American women, a safety intervention protocol significantly increased the safety behaviors adopted by the women.

POTENTIAL HARMS

Sedatives, tranquilizers, anxiolytics, and antidepressants can undermine the patient's ability to deal with abusive situations; therefore, caution should be exercised in prescribing to victims of domestic violence. The domestic violence victim whose symptoms are treated without the underlying cause being diagnosed enters a cycle of contacts with medical and mental health providers in which he/she can become increasingly debilitated while at the same time exhausting the resources available to the patient.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for release, a member group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

Key Implementation Recommendations

The following system changes were identified by the guideline work group as key strategies for health care systems to incorporate in support of the implementation of this guideline.

1. Establish the health care setting as a safe, comfortable appropriate place in which to discuss domestic violence issues. Opportunities exist in the form of patient education, informational displays, etc.
2. Train staff to recognize and screen patients for abuse, including:

- Recognition that domestic violence may be in the form of physical, emotional/psychological, social and sexual abuse, and may exist in both heterosexual and same-sex relationships.
- Patients, whether or not experiencing abuse or denying abuse, are routinely offered information regarding domestic violence resources and support in a non-threatening manner.
- Patients confirming abuse are assessed for their immediate safety status, have available options and written resource materials offered, and are offered contact with a domestic violence advocate.
- Documentation is thorough and complete, supported by subjective and objective data, and maintained in a highly confidential manner.

3. Develop a step-by-step safety plan to guide the patient should he or she choose to seek additional assistance.
4. Establish relationships with community resources to expand resources available to victims of domestic violence.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Pocket Guide/Reference Cards
Quality Measures
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED NQMC MEASURES

- Domestic violence: percentage of health care staff trained in initial assessment of problems of domestic violence every twelve months.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Sep. 46 p. [87 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 Jun (revised 2006 Sep)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; e-mail: icsi.info@icsi.org; Web site: www.icsi.org.

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GUIDELINE COMMITTEE

Committee on Evidence-Based Practice

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, the Institute for Clinical Systems Improvement (ICSI) has adopted a policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse impact on the content of the guideline. Readers of the guideline may assume that only work group members listed below have potential conflict of interest to disclose.

No work group members have potential conflicts of interest to disclose.

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GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Domestic violence. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 51 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Institute for Clinical Systems Improvement (ICSI) Web site.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Domestic violence. Executive summary. Bloomington (MN): Institute for Clinical Systems Improvement, 2006 Sep. 1 p. Electronic copies: Available from the Institute for Clinical Systems Improvement (ICSI) Web site.
- ICSI pocket guidelines. April 2006 edition. Bloomington (MN): Institute for Clinical Systems Improvement, 2006. 298 p.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

The following implementation tools are available in the Annotation Appendices of the original guideline document:

- Annotation Appendix B – Screening instruments: abuse assessment screen
- Annotation Appendix C – Danger assessment
- Annotation Appendix E – Safety Planning

Electronic copies: Available in the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on July 10, 2000. The information was verified by the guideline developer on April 25, 2001. This summary was updated by ECRI on April 15, 2002. The updated information was verified by the guideline developer as of June 3, 2002. This summary was updated again on September 3, 2003. The information was verified by the guideline developer on November 26, 2003. This summary was updated again by ECRI on September 15, 2004, January 19, 2005, and December 4, 2006. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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